CERTIFICATE
OF ATTENDANCE

This is to certify that

Eka Fithra

has participated in

8th ISICAM-InaLIVE
Indonesian Society of Interventional Cardiology Annual Meeting

Workshop Peripheral Vascular Disease Awareness
"Early Diagnostic, Management, and Referral"

Fairmont Hotel, Senayan, Jakarta
November 19, 2016
as

SPEAKER

Muhammad Munawar, MD, PhD, FIHA
President, Indonesian Society of
Interventional Cardiology (ISIC)

Mei Lestari, MD, FIHA
Chairman, 8th ISICAM-InaLIVE

Accredited by Indonesian Medical Association No. 00735/PB/A.4/11/2016 - Participant 5 SKP, Speaker 12 SKP, Moderator 4 SKP, Organizing Committee 3 SKP

The 8th Indonesian Society of Interventional Cardiology Annual Meeting
(8th ISICAM-InaLIVE)
Nov 18th–20th, 2016, Fairmont Hotel, Jakarta, Indonesia

8th ISICAM-InaLIVE
Indonesian Society of Interventional Cardiology Annual Meeting

Secretariat: Indonesian Society of Interventional Cardiology,
National Cardiovascular Center "Harapan Kita" Hospital
Wisma Harapan Kita, 2nd Floor, Jl. Let Jen S. Parman Kav.87, Jakarta 11420-Indonesia
Ph: 62-21-5681149, Fax: 62-21-5684220
Email: isicam@isic.or.id or piki.indo@isic.or.id; web: www.isicam.org or www.isic.or.id

Jakarta, September 27, 2016

To:
Eka Fithra, MD, FIHA

Dear Dr. Fithra,

On behalf of the **Indonesian Society of Interventional Cardiology (ISIC),** it is a great pleasure to inform you that **The 8th Indonesian Society of Interventional Cardiology Annual Meeting – Indonesia Live (ISICAM-InaLIVE)** will be held at Fairmont Hotel, Jakarta, Indonesia on November 18-20, 2016.

The member of **Indonesian Society of Interventional Cardiology (ISIC)** is increasing rapidly over the last 6 years. Thus it is felt necessary that this year **ISIC** should involve more members as speaker, moderator, operator and panelist in the **8th ISICAM-InaLIVE**. We consider this opportunity as honor and trust to ISIC members, so we really hope that you would contribute for the success of this meeting. Unfortunately, the organizing committee of the **8th ISICAM-InaLIVE** could only support **free registration** for this year.

We will be honored to have you in our event as ***Speaker*** on the following session:

WORKSHOP OPTIMIZING OUTCOME WITH INNOVATION IN CARDIOVASCULAR INTERVENTION
Awareness in Peripheral Vascular Disease "Early Diagnostic, Management, and Referral"
(Speaker)
Day, date : Saturday, November 19, 2016
Time : 09:00 – 09:20 (20 minutes)
Venue : Ruby 1&2, Fairmont Hotel, Jakarta
Topic : Critical Limb Ischemia : Not an Ordinary Leg Pain

Kindly refer to the complete schedule below:

WORKSHOP OPTIMIZING OUTCOME WITH INNOVATION IN CARDIOVASCULAR INTERVENTION
Awareness in Peripheral Vascular Disease "Early Diagnostic, Management, and Referral"
(Speaker)
Day, date : Saturday, November 19, 2016
Time : 08:00 – 15:00 (7 hours)
Venue : Ruby 1&2, Fairmont Hotel, Jakarta
Director : Taofan

Time	Agenda	Speaker
07.30-08.00	Re-registration	
08.00-08.20	Opening	
Moderator: Arif Nugroho		
08.20-08.40	Introduction : All About Peripheral Vascular Disease	Ismoyo Sunu
08.40-09.00	Screening and Peripheral Vascular Examination	Firizkita Dewi

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09.00-09.20	**Critical Limb Ischemia : Not an Ordinary Leg Pain**	**Eka Fithra**
09.20-09.40	Diabetic Foot : Vascular' Point Of View	Hariadi Hariawan
09.40-10.00	Early Diagnostic and Management of Acute Limb Ischemia	Bagus Ari Pradnyana
10.00-10.20	Coffee Break	
10.20-10.40	Understanding and Managing Chronic Vein Insufficiency	J Nugroho
10.40-11.00	Overview of Pulmonary Embolism and Its Challenges	Muhammad Saifur Rohman
11.00-11.30	Case Discussion	
11.30-13.00	Prayer and Lunch	
Moderator: Januar W. Martha		
13.00-13.20	Getting Aware of Aorta Dissection	Iddar Mappangara
13.20-13.40	Aortic Aneurysm : Jumpstart Your Judgement	Bagus Herlambang
13.40-14.00	Lymphedema: What to Know	Edmond Leonard Jim
14.00-14.30	Discussion	
14.30-15.00	Feedback and Closing Remarks	

Attached the **reply form** which needs to be completed and please return to us before **October 4, 2016.** To facilitate your participation, would you be kind enough sending us your current Curriculum Vitae and latest photograph in .jpeg format to: Secretariat of the 8th ISICAM-InaLIVE, Jakarta – isicam@isic.or.id or piki.indo@isic.or.id

We believed that your contribution will be valuable for the success of the meeting. Should you have any question, please do not hesitate to contact **the 8th ISICAM-InaLIVE Secretariat** at +6221–5681149, fax: +6221–5684220 or isicam@isic.or.id or piki.indo@isic.or.id.

We are thanking you in advance for your kind cooperation and support.

Sincerely yours,

Mei Lestari, MD, FIHA
Chairman, the 8th ISICAM-InaLIVE

Dafsah A. Juzar, MD, FIHA
Secretary, the 8th ISICAM-InaLIVE

Critical Limb Ischemia

Not an Ordinary Leg Pain

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INDONESIAN SOCIETY OF INTERVENTIONAL CARDIOLOGY ANNUAL MEETING

Eka Fithra Elfi

Cardiology and Vascular Medicine Department

Faculty of Medicine Andalas University Padang

- I do not have any potential conflict of interest

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Case Illustration

- Mr. P, an 81-year-old man with history of hypertension, diabetes, and hyperlipidemia presents with a slowly enlarging ulcer on the left heel over a 5-month period. The ulcer was preceded by pain that localizes to the base of the toes, described as "burning pain." The pain is present at rest, worsens when lying in bed or with foot elevation, and is alleviated by dangling the foot in dependent position.
- In addition, he has a prior history of claudication symptoms, described as a dull achy pain in the left calf with walking two blocks, and relieved with rest. He is a former smoker with a 20 pack-year history, and denies history of stroke or known coronary artery disease. He has never had a deep venous thrombosis.

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Critical Limb Ischemia: Introduction

A condition characterized by chronic (≥2 weeks) ischemic rest pain, nonhealing wound/ulcers, or gangrene in 1 or both legs attributable to objectively proven arterial occlusive disease

- It is an advanced and severe form of peripheral arterial disease, in several cases preceeded by claudication
- CLI tends to have severe morbidity and mortality with poor prognosis, despite optimal management.

Santilli JD. Am Fam Physician. 1999

4

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SISICAM-InaLIVE

CLI: diagnostic modality

- Toe-Brachial Index (TBI) or Toe Pressure
  Indicated for noncompressibel or non diagnostic ABI

Tendera M. Eur Heart Jour. 2011

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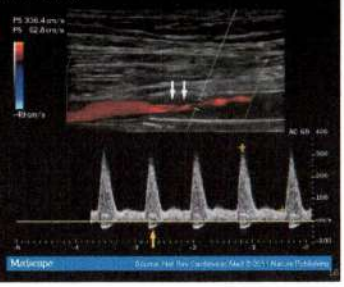
SISICAM-InaLIVE

CLI: diagnostic modality

- Duplex ultrasound



Tendera M. Eur Heart Jour. 2011

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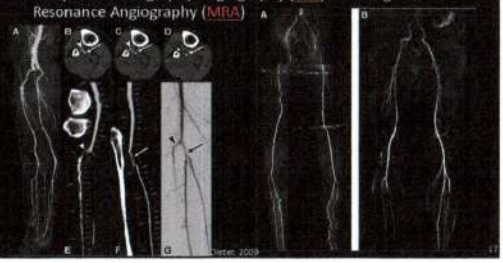
SISICAM-InaLIVE

CLI: diagnostic modality

- Computed Tomography Angiography (CTA) and Magnetic Resonance Angiography (MRA)



Dieter 2009

19

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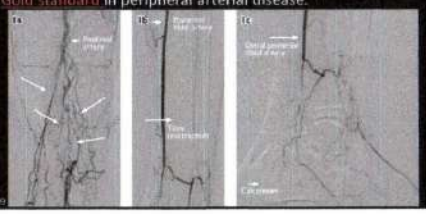
SISICAM-InaLIVE

CLI: diagnostic modality

- Digital-substraction Angiography (DSA)
  Invasive imaging with radiation and contrast agent.
  Gold standard in peripheral arterial disease.



Dieter 2009

20

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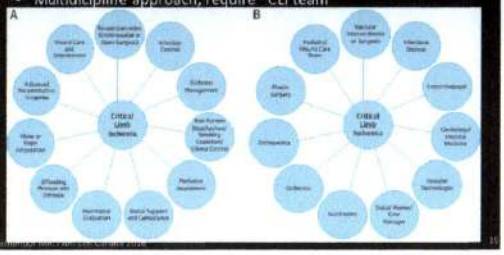
CLI: Comprehensive management

- Multidicipline approach, require "CLI team"



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SISICAM-InaLIVE

CLI: conservative and prevention

- Risk factors modification (smoking cessation, reduce blood pressure and body weight, control diabetes and cholesterol level,)
- Management for any present comorbid disease (heart failure, chronic kidney disease)
- Antiplatelet, statin therapy, and beta blocker
- Selected shoes and modification of walking habit to reduce trauma and shear stress to the foot.

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SISICAM-InaLIVE

CLI: wound care and pain control

- Debridement for any necrotic or gangrene tissue
- Routine wound care
- Control infection with antibiotics
- Hyperbaric therapy ?
- Reduction of pain with morphine or prostanoid

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CLI: revascularization

- Class I level of Evidence A for CLI
- Options included endovascular intervention, vascular surgery, or hybrid procedure

Recommendations	Class[a]	Level[b]	Ref[c]
For limb salvage, revascularization is indicated whenever technically feasible.	I	A	302, 331, 336
When technically feasible, endovascular therapy may be considered as the first-line option.	IIb	B	302, 331
If revascularization is impossible, prostanoids may be considered.	IIb	B	338, 339

Tendera M. Eur Heart Nurs 2011

24


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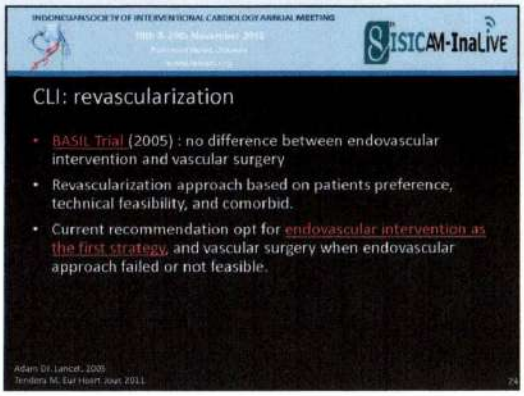
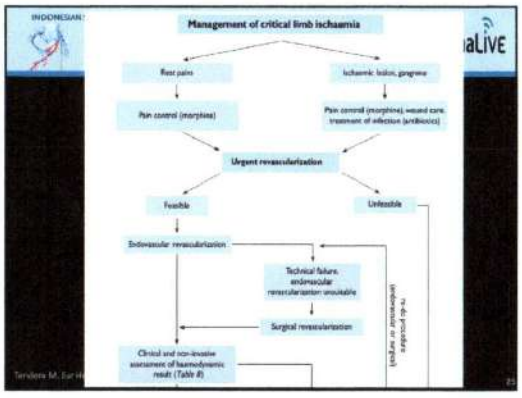
SISICAM-InaLIVE
CLI: revascularization
To stent or to open surgery

25


INDONESIAN SOCIETY OF INTERVENTIONAL CARDIOLOGY ANNUAL MEETING
SISICAM-InaLIVE
CLI: revascularization
• BASIL Trial (2005) : no difference between endovascular intervention and vascular surgery
• Revascularization approach based on patients preference, technical feasibility, and comorbid.
• Current recommendation opt for endovascular intervention as the first strategy, and vascular surgery when endovascular approach failed or not feasible.
Adam DJ. Lancet. 2005
Tendera M. Eur Heart Jour. 2011

26


Management of critical limb ischaemia
Rest pains
Ischaemic lesion, gangrene
Pain control (morphine)
Urgent revascularization
Feasible
Unfeasible
Endovascular revascularization
Technical failure, endovascular revascularization unsuitable
Surgical revascularization
Clinical and non-invasive assessment of haemodynamic result (Table II)

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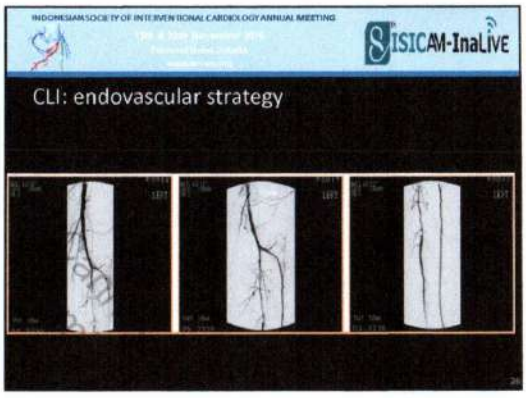
INDONESIAN SOCIETY OF INTERVENTIONAL CARDIOLOGY ANNUAL MEETING
SISICAM-InaLIVE
CLI: endovascular strategy

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SICAM-InaLIVE

CLI: clinical criteria

Fontaine classification			Rutherford classification		
Stage	Symptoms	⟷	Grade	Category	Symptoms
I	Asymptomatic	⟷	0	0	Asymptomatic
II	Intermittent claudication	⟷	I	1	Mild claudication
		⟷	I	2	Moderate claudication
		⟷	I	3	Severe claudication
III	Ischemic rest pain	⟷	II	4	Ischaemic rest pain
IV	Ulceration or gangrene	⟷	III	5	Minor tissue loss
		⟷	III	6	Major tissue loss

Tendera M. Eur Heart Jour. 20

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SICAM-InaLIVE

CLI: diagnostic modality

- Ankle-Brachial Index or Ankle Pressure

  CLI usually ABI <0.5 and Ankle Pressure <50 mm Hg

Tendera M. Eur Heart Jour. 20

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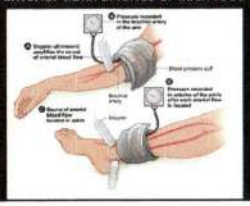
SICAM-InaLIVE

CLI: ABI

- 10–12 cm sphygmomanometer cuff placed just above the ankle
- Doppler instrument (5–10 MHz) to measure the pressure of the posterior and anterior tibial arteries of each foot



Stoval DP. Vasc Med. 2008

15

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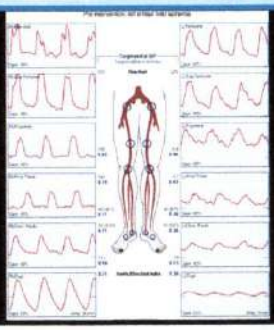
SICAM-InaLIVE

CLI: ABI



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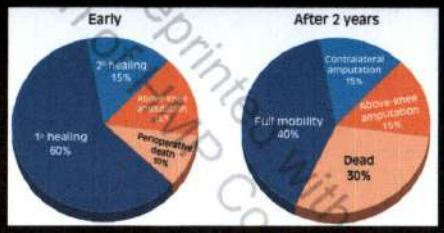
ISICAM-InaLIVE

CLI: medical burden



Fate of CLI after amputation

Shishehbor MH. Cleveland Clin Journ of Med. 2014

9

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ISICAM-InaLIVE

CLI: Risk Factors

- CLI considered increase cardiovascular risk factors → atherosclerotic disease
- Atherosclerotic risk factors increased risk of PAD and CLI : diabetes, smoking, hypertension, hypercholesterolemia, advanced age
- Diabetes, obesity and smoking accelerate disease progression to CLI

Shishehbor MH. J Am Coll Cardiol 2016

10

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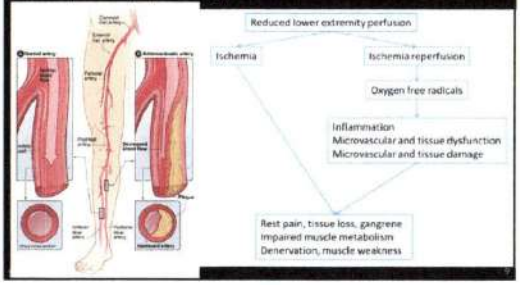
ISICAM-InaLIVE

CLI: pathophysiology



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ISICAM-InaLIVE

CLI: Clinical Presentation

- Ischemic rest pain : increased with foot elevation and decreased with lowering extremities, particularly in toe and forefoot
- Impaired walking function
- Dry skin, loss of subcutaneous fat and muscle atrophy
- Cold peripheral with decreased or absent pulses
- Non healing wound, ulceration and gangrene in bony prominence, plantar surface of foot, heel, and toe

Sikvist DP. Vasc Med. 2008

12

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CLI: medical burden

- High mortality and morbidity
- 2.5 million patients in USA; 6,000 new cases annually
- 0.1% to 0.3% global prevalence worldwide, increased with diabetes, smoking, and obesity
- Low survival rate, 30% mortality rate in the first year of treatment, up to 60%-70% mortality after 5 years.
- 25% amputation rate and 10% of major cardiovascular event (myocardial infarction, stroke, and cardiac death) in the first year

Soes T. IACC. 2014

5

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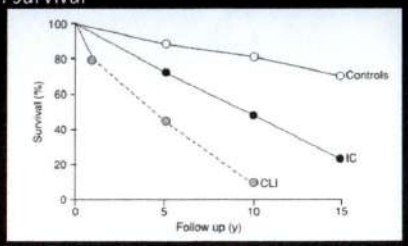
CLI: survival



Survival of CLI

Shishehbor MH. Cleveland Clin Jour of Med. 2014

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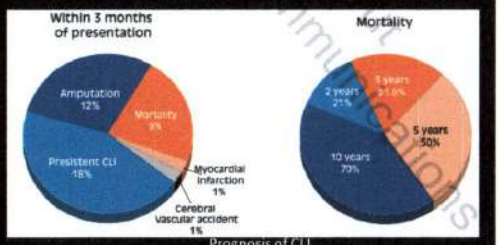
ISICAM-InaLive

CLI: survival



Prognosis of CLI

Shishehbor MH. Cleveland Clin Jour of Med. 2014

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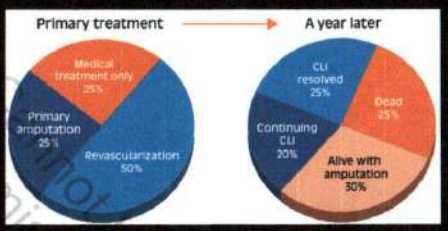
CLI: medical burden



Shishehbor MH. Cleveland Clin Jour of Med. 2014

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ISICAM-InaLive

Case Illustration

- An 81-year-old man with a history of hypertension, diabetes, and hyperlipidemia presents with a slowly enlarging ulcer on the left heel over a 5-month period. The ulcer was preceded by pain that localizes to the base of the toes, described as "burning pain." The pain is present at rest, worsens when lying in bed or with foot elevation, and is alleviated by dangling the foot in dependent position.
- In addition, he has a prior history of claudication symptoms, described as a dull achy pain in the left calf with walking two blocks, and relieved with rest. He is a former smoker with a 20 pack-year history, and denies history of stroke or known coronary artery disease. He has never had a deep venous thrombosis. Four months prior to presentation, the patient underwent stenting of the left superficial femoral artery (SFA) and balloon angioplasty of the peroneal artery. Following the procedure, the patient had a temporary relief of leg pain, but the ulcer failed to heal.

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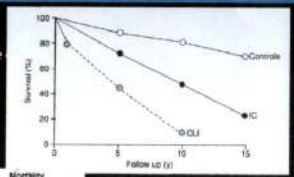
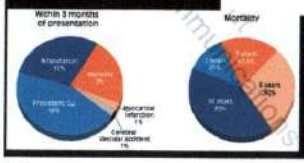
CLI: survival

Survival rate





Prognosis of CLI

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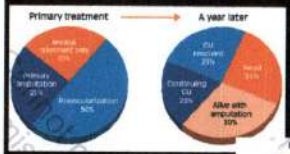
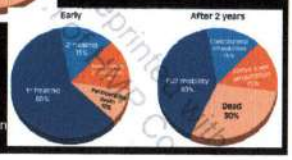
CLI: medical burden



Natural history of CLI



Fate of CLI after amputation

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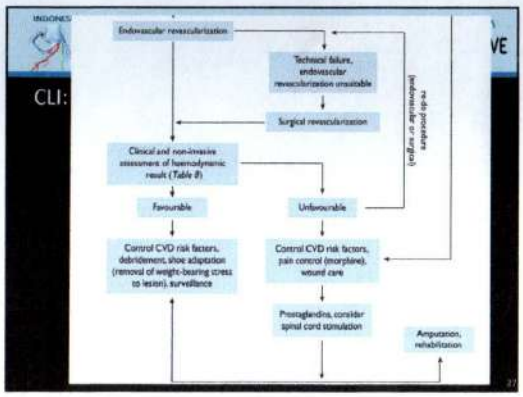

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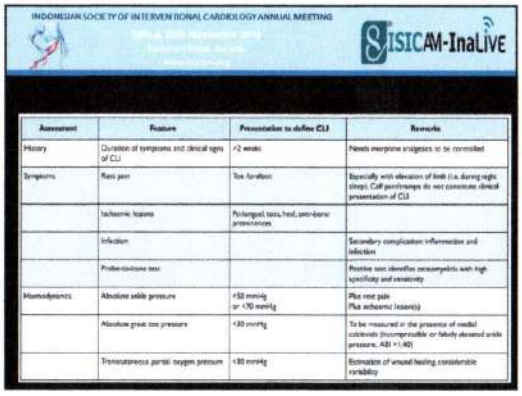

Assessment	Feature	Presentation to define CLI	Remarks
History	Duration of symptoms and clinical signs of CLI	>2 weeks	Needs morphine analgesics to be controlled
Symptoms	Rest pain	Toe, forefoot	Especially with elevation of limb (i.e. during night sleep). Calf pain/cramps do not constitute clinical presentation of CLI
	Ischaemic lesions	Perilungual, toes, heel, pressure areas	
	Infection		Secondary complication: inflammation and infection
	Probe-to-bone test		Positive test identifies osteomyelitis with high specificity and sensitivity
Haemodynamics	Absolute ankle pressure	<50 mmHg or <70 mmHg	Plus rest pain Plus ischaemic lesion(s)
	Absolute great toe pressure	<30 mmHg	To be measured in the presence of medial calcinosis (incompressible or falsely elevated ankle pressure, ABI >1.40)
	Transcutaneous partial oxygen pressure	<30 mmHg	Estimation of wound healing, considerable variability

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